Specialized Pediatric Eye Care & Adult Strabismus

www.specializedpediatriceyecare.com

Patient: _____ **DOB:** _____ **Account #:** _____
(OFFICE USE ONLY)

Address: _____ _____ _____ _____ **Gender (M/F/Other):**_____
Street City/Town State Zip **Pronouns**:_____

Occupation OR School Grade: _____ **Family E-mail:** _____
Home #: _____ **Cell #:** _____ **Work #:** _____

Who is filling out this form? Name: _____ **Relationship to Patient:** _____

Who has guardianship of the patient? (For each guardian, list name + relationship to child + email)
_____
_____

Insurance Guarantor's Name: _____ **DOB:**_____

Insurance Guarantor's Address (if different):_____

Siblings and DOB: _____

Who referred you to us? _____

Primary Care Physician: _____ **Referring Physician:** _____
Practice Name: _____ **Practice Name:** _____

Pharmacy Name: _____
(Address / Location) _____

Spoken Language: _____ **Ethnicity:** Hispanic (Yes/No) ____
Race (check all that apply)**:**
____White ____Black/African American ____American Indian/Alaskan Native ____Asian ____Native Hawaiian/Pacific Islander
Other _____

Household Cigarette Smoking? ____Yes ____No **Does the patient smoke?** ____Yes ____No ____Quit (When:_____)

Current Medications: ____None
(if known, include dosage & over the counter medications)
_____ _____
_____ _____

Medication Allergies: ____None
_____ **Reaction:** _____
_____ **Reaction:** _____
_____ **Reaction:** _____

Current Eye Drops: _____ **Latex Allergy:** ____Yes ____No

REASON FOR VISIT: _____

Fill out this section ONLY if the patient is a CHILD:
Current Weight: _____lbs Current Height: _____ Birth Weight: ____lbs _____oz (_____ grams)
Premature Birth? ____YES ___NO If yes, born at how many weeks? _____ Was delivery a C-section? ____YES ____NO
Does your child have developmental delays? ____YES ____NO If yes, describe: _____
Is your child enrolled in Early Intervention? ____YES ____NO If yes, list services:_____

Patient's Recent Symptoms: (check all that apply)

____Eyes (vision loss/change, burning, itching redness)
____General (eg.weight change, fever, increased thirst)
____Cardiovascular (ex. Chest pain, shortness of breath)
____Brain/Nervous System (ex. numbness, seizures)
____Psychiatric (ex. anxiety, depression)
____Bone, Joint, Muscle (ex. pain, swelling, stiffness)
____Neurological (ex. difficulty speaking/swallowing)
____Ear, Nose, Throat (eg. hearing loss, dizziness)
____Allergic (ex. Hay fever, allergies to new meds/foods)
____Blood/Lymph Nodes (ex. excessive bleeding, bruising)
____Skin (ex. masses, lesions, infection, rashes)
____Endocrine (ex. Thyroid disease/frequent urination)

Patient's Eye History: (check all that apply))

____Previous eye exam with an eye doctor?
____Eye Glasses
- If yes, what age were they first prescribed? _____
- If yes, how old is the current pair? _____

____Prisms
- If yes, when prescribed? _____

____Contact Lenses
____Eye Muscle Surgery
- If yes, when? _____

____Other Eye Surgery?
- Describe and when? _____

____Ambyopia (lazy eye) and/or Eye Patching
____Eye Exercises
____Strabismus (eyes misaligned)
____Glaucoma
____Cataracts
____Retinal Disease
____Nystagmus
____Diabetic Eye Disease
____Recurring "Pink Eye"
____Stye
____Eye Injury
Other: _____
(***PLEASE LIST ANY EYE HISTORY NOT LISTED ABOVE)***

Patient's Medical History: (check all that apply)

____Arthritis
____Asthma
____Bleeding Disorder
____Diabetes
____Environmental Allergies
____Hearing Loss
____Heart Disease
____Cancer (Type: _____)
____HIV/AIDS
____High Blood Pressure
____High Cholesterol
____Kidney Disease
____Lung Disease
____Migraines
____Stroke
____Seizure
____Thyroid Disease
____Neurologic Disease (Describe:_____)
____Genetic Condition (Describe:_____)
____ADD/ADHD
____Autism Spectrum/PDD
____Developmental Delays
____Learning Disability (Describe:_____)
____IEP (Services:_____)
Other: _____
(PLEASE LIST MEDICAL HISTORY NOT LISTED ABOVE)

Does the patient have any missing immunizations? ____NO ____YES
If yes, please explain: _____
***Does the patient or any family members have complications from anesthesia*?** ____NO ____YES

Family Eye and Medical History: (check all that apply and indicate which family members) ____**None**

____Amblyopia (lazy eye) or Eye ____Patching _____
____Strabismus (eye misalignment) _____
____Eye Muscle Surgery _____
____Eye Glasses (before age 6 years) _____
____Blindness (in childhood) _____
____Blindness (in adulthood) _____
____Cataracts (in childhood) _____
____Glaucoma (in childhood) _____
____Retinal Detachment _____
____Retinitis Pigmentosa _____
____Color Blindness _____
____Genetic Disease _____
____Neurologic Disease _____
____Cancer _____
____Diabetes _____

Other eye or medical conditions? (please list) _____

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PAYMENTS / NO SHOW / CANCELLATION POLICIES

1. **Insurance:** We participate with ***most*** major insurance plans, including Medicare. If you are not insured by a plan, payment in full is expected at the end of each visit. If you are insured by a plan we participate with but do not have an up-to-date insurance card, payment in full may be required until we can verify your coverage. Knowing your insurance benefits is ***your*** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-Payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay at the time of service, your appointment may be rescheduled.
3. **Non-Covered Services:** Please be aware that some-and perhaps all- of the services you receive maybe non-covered or not considered medically necessary by Medicare or other insurances. You must pay for these services in full at the time of your visit.
4. **Proof of Insurance:** All patients must complete our patient information forms before seeing the provider. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.
5. **Claim Submission:** We will submit your claims and assist you in any reasonable way we can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Insurance Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.
7. **Divorce / Separation:** In case of divorce or separation, the party responsible for payment on the account is the parent authorizing treatment of the child. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We do not forward bills to other parties regardless of court rulings or divorce decrees.
8. **Returned Checks:** If the bank imposes a fee for a returned check, that fee will be passed on to the patient.
9. **Non-Payment:** If your account is over 90 days past due, we may refer your account to a collection agency. If your account is sent to a collections agency due to non-payment of services provided, there will be a $30 fee added to your account in addition to your outstanding balance.
10. **No Show/Cancellation:** If you must cancel or reschedule an appointment, we kindly ask that you call as soon as you can, preferably at least 24 hours before your scheduled appointment time. Failing to show up for your appointment is considered a "no show." After 3 "no shows", it is our policy to discharge the patient from the practice.

I have **read and understand** the payment policy and agree to abide by its guidelines.

_____ _____/_____/_____
Print Patient Name Patient Date of Birth

_____ _____/_____/_____
Signature of Patient or Guardian Date

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PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will:

- Adhere to the standards set forth in the Notice of Privacy Practices.

- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will:
    - Implement reasonable measures to protect the integrity of all PHI maintained about patients.

- Recognize that patients have a right to privacy. Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy.
    - To the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.

- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
    - Not disclose PHI data unless the patient (or his or her authorized representative) has properly consented to or authorized the release or the release is otherwise authorized by law.

- Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
    - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

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- All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice.

- All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

- Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request. The patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will:
    - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial.
    - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

- All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as their requests are in writing.

_____ _____

Print Patient Name Patient Date of Birth

_____ _____

Patient or Guardian Signature Date

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LIFETIME INSURANCE AUTHORIZATION AND RELEASE FOR MEDICAL INFORMATION

I REQUEST THAT PAYMENT OF THE AUTHORIZED HEALTH INSURANCE BENEFITS (EG: MEDICARE, MEDICAID, MEDEX BLUE SHIELD, WORKMAN'S COMPENSATION, COMMERCIAL, ETC.) BE MADE TO ME OR ON MY BEHALF TO SPECIALIZED PEDIATRIC EYE CARE, INC. FOR ANY SERVICES FURNISHED BY THE PHYSICIANS AND STAFF EMPLOYED THERE.

I AUTHORIZE ANY INSURANCE CARRIER AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

ONCE SPECIALIZED PEDIATRIC EYE CARE HAS OBTAINED MY ONE-TIME AUTHORIZATION, THEY MAY SUBMIT ANY LATER INSURANCE CLAIMS ON EITHER AN ASSIGNED OR NON-ASSIGNED BASIS, WITHOUT SUBMITTING CLAIMS, THEY SHOULD INDICATE IN THE PATIENTS SIGNATURE SPACE:

Patient Signature or Authorized Signer	Today's Date
Account # (office use only)	Date of Birth

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REFERRAL WAIVER

Many insurance companies today require that patients secure a **REFERRAL** from their primary care physician (**PCP**) before being seen by a specialist under certain circumstances.

Because there are numerous insurance plans (even within the same insurance company), it's impossible for us to keep track of when referrals are necessary and when they are not. The circumstances vary from plan to plan.

As a result, we must insist that each individual patient assume responsibility for securing referrals when they are needed. If you are not sure when you need to get a referral, please inquire with your insurance company.

If your insurance company rejects our claim for services rendered due to "failure to secure referral from PCP", you will be held personally accountable to pay the bill.

It must be clearly understood that the responsibility to secure referrals is the patient's and not ours.

We are always happy to submit a claim to your insurance company for services rendered. However, in many cases, your insurance company does not cover any service which is not approved, arranged or provided by your PCP (please consult your Member Handbook for a list of services which require a referral from your PCP).

Your signature below indicates that if you receive specialty care services **without the consent of your PCP**, you will assume financial responsibility for such services.

Patient's Name (Type or Print) _____ Patient's Date of Birth _____

Signature of Patient or Guardian _____ Date of Service _____

Please check below which doctor you have requested a referral for:

____Danielle Ledoux, MD
Specialized Pediatric Eye Care
77 Herrick St, Unit 102
Beverly, MA 01915
Phone: 978-338-4321
Fax: 978-927-1010

____O'ine McCabe, MD
Specialized Pediatric Eye
Care 77 Herrick St, Unit 102
Beverly, MA 01915
Phone: 978-338-4321
Fax: 978-927-1010

____
Jacqueline Kenney, OD
Specialized Pediatric Eye
Care 77 Herrick St, Unit 102
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Phone: 978-338-4321
Fax: 978-927-1010

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REFRACTION FEES

Please be advised that your insurance **may not** pay for the *"refractive"* portion of your eye exam. This is the portion of the exam that determines whether or not you need to wear glasses or need a change in your glasses prescription. Many insurances consider this a *"non-covered"* service.

Your insurance will only pay for the *"medical"* portion of your eye exam (except for the normal deductibles and co-payments which are your responsibility).

As a result, we are now required to charge you for the refractive portion of your exam. This will be a $70.00

If you are refracted today, you will be asked to pay this $70.00 fee if your insurance does not cover it.

Please be reminded that this fee is in addition to the normal deductibles and co-pays that your insurance company always requires for the medical portion of your exam.

If you have any questions about this policy, please be certain to ask one of our staff members or call your insurance company.

Thank you for your understanding.

_____ _____/_____/_____

Patient Name Patient Date of Birth

_____ _____/_____/_____

Signature of Patient or Guardian Date